Bureau of Licensure and Certification

		(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
NVS5265AGC				B. WING		08/27/2008			
NAME OF PROVIDER OR SUPPLIER SANFIL DREAM HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1709 RYAN AVE LAS VEGAS, NV 89101						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
Y 000	Initial Comments This Statement of Deficiencies was generated a result of the initial State Licensure survey conducted at your facility on August 27, 2008. The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006. The facility requested a license for 6 total beds NOTE: The facility meets the space requireme for six beds by utilizing all four bedrooms within the facility. The facility had the following category of classified beds: Category 1 - 3 beds; and Category 2 - 3 beds. The facility had the following endorsements: Residential facility for the elderly or disabled persons Residential facility for persons with mental illnesses The census at the time of the survey was 0. O mock resident file was reviewed and 3 employer files were reviewed. No complaints were investigated during the survey. The findings and conclusions of any investigation.		ed as 8. the 2006. eds. ment thin	Y 000			DAIL		
	by the Health Divisio prohibiting any crimir actions or other clain	clusions of any investign shall not be construed all or civil investigations of relief that may be ander applicable feder	d as s,						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Licensure and Certification

AND DIAM OF CODDECTION		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME	() ==		(X3) DATE SURVEY COMPLETED - 08/27/2008			
	ROVIDER OR SUPPLIER	NV35265AGC	STREET ADDRESS, CITY, STATE, ZIP CODE 1709 RYAN AVE LAS VEGAS, NV 89101					
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Y 000	Continued From pa	age 1		Y 000				
	The following regul identified:	latory deficiencies were						
Y 051	449.194(2) Administrator's Responsibilities-Designation			Y 051				
	NAC 449.194 The administrator of a residential facility shall: 2. Designate one or more employees to be in charge of the facility during those times when the administrator is absent. Except as otherwise provided in this subsection, employees designated to be in charge of the facility when the administrator is absent must have access to all areas of and records kept at the facility. Confidential information may be removed from the files to which the employees in charge of the facility have access if the confidential information is maintained by the administrator. The administrator or an employee who is designated to be in charge of the facility pursuant to this subsection shall be present at the facility at all times. The name of the employee in charge of the facility pursuant to this subsection must be posted in a public place within the facility during all times that the employee is in charge.							
	This Regulation is not met as evidenced by: Based on record review and interview, the administrator failed to designate one or more employees to be in charge of the facility during those times when the administrator would be absent.							
	Findings include:							
No written statement designated an empl			ee to					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
NVS5265AGC			B. WING		08/27/2008				
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE				
SANFIL DREAM HOME				RYAN AVE VEGAS, NV 89101					
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Y 051	Continued From page	2		Y 051					
	be in change when the Administrator was not present within the facility.								
		d that an employee not rge when the Administr n the facility.							
Y 070	 449.196(1)(f) Qualifications of Caregiver-8 hours training NAC 449.196 1. A caregiver of a residential facility must: (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. 			Y 070					
	This Regulation is not met as evidenced by: Based on record review, the facility failed to ensure 8 hours of training for 1 of 3 employees. (#1)								
	Findings include:								
		re date 2005) did not evidence of eight hours e needs of the residents							
Y 072	449.196(3) Qualication re-training	ns of Caregiver-Med		Y 072					
	facility in the administ including, without limi	ts a resident of a reside tration of any medicatio tation, an over-the-cour supplement, the caregi	n, nter						

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
		NVS5265AGC				08/	27/2008	
NAME OF PROVIDER OR SUPPLIER SANFIL DREAM HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1709 RYAN AVE LAS VEGAS, NV 89101					
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Y 072	pursuant to NRS 449 training in the manag caregiver must receiv 3 years and provide t satisfactory evidence and his attendance a	on to the training require 1.037, at least 3 hours of the training at least 6 the residential facility where of the content of the training; and the training; and the training; and the training; and the training t	of The every ith aining	Y 072				
Y 435	This Regulation is not met as evidenced by: Based on record review, the facility failed to ensure that 1 of 3 employees had the require training in medication management. (#3) Findings include: Employee #3's file (hire date 7/1/05) did not contain evidence the employee completed th required medication management training. 449.229(4) Fire Extinguisher; Inspection NAC 449.229 4. Portable fire extinguishers must be inspect recharged and tagged at least once each yea a person certified by the State Fire Marshall conduct such inspections. This Regulation is not met as evidenced by:		ed cted, ear by to	Y 435				
	Based on observation the single fire extingu							

PRINTED: 09/30/2008 FORM APPROVED Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING _ NVS5265AGC 08/27/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1709 RYAN AVE SANFIL DREAM HOME LAS VEGAS, NV 89101 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Y 435 Continued From page 4 Y 435 annually. Findings include: The fire extinguisher in the facility had an inspection tag dated August 17, 2007.

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